Mercy Medical Center
Surgical Oncology New Patient Questionnaire

Age: _____

Name: _____ Today's Date: _____

Reason for your visit today: _____

_____

_____

_____

_____

Do you have or have you ever been treated for? (please check)

☐Migraines	☐Congestive Heart Failure	☐Dialysis	☐Heart Attack (MI)
☐Stroke or Mini Stroke	☐High Cholesterol	☐Anxiety	☐GERD/reflux
☐Seizure Disorder	☐Kidney Disease	☐Ulcer	☐Sleep Disorder
☐Epilepsy	☐Diabetes	☐Depression	☐Osteoporosis
☐Thyroid Problems	☐Deep Vein Thrombosis (clots)	☐Hepatitis	☐Arthritis
☐Asthma	☐Anemia	☐Pancreatitis	☐Kidney Stones
☐Angina	☐Hepatitis/Liver Disease	☐Cancer	☐Parathyroid Problems
☐COPD (bronchitis, emphysema)	☐Hypertension (high blood pressure)	☐HIV/AIDS	☐Other:
☐Tuberculosis	☐Claudication (pain in legs w/ walking)	☐Gout	

List all **operations** and **hospitalizations** that you have had in the past, including **dates**:

Have you ever had a blood transfusion? _____ Recent Serious Injury? _____

Are you currently taking Blood Thinners? ☐ yes ☐ no Aspirin? ☐ yes ☐ no Ibuprofen? ☐ yes ☐ no

Social History:

Religious Preference _____ Type of work? _____ Do you exercise? ☐ yes ☐ no

Do you smoke? ☐ yes ☐ no Have you ever smoke? ☐ yes ☐ no When did you quit? _____

How long? _____ year How much? _____ packs per day Advance Directives (living will) ☐ yes ☐ no

Do you drink alcohol? ☐ yes ☐ no How much? ☐ 1-5 drinks per month ☐ 1-5 per week ☐ 1-5 daily

Do you use drugs? ☐ yes ☐ no If yes what type? _____

Are you married? ☐ yes ☐ no Number of children _____

Screening Tests: provide dates and results

Last Mammogram _____ Last PAP _____ Last colonoscopy/sigmoidoscopy_____ Last PSA _____

Result _____ Result _____ Result _____ Result _____

for clinician
(GAIL: 1) race _____ 2) age____ 3) 1st menses_____ 4) 1st live birth_____ 5) # of sis/daughter/mom w/BrCa____
6) #Br Bx_____7)Bx w/atypica_____ (5year risk _____ LT risk _____)

Family History:

Is your mother still living? ☐ yes ☐ no Age? _____ Is your father still living? ☐ yes ☐ no Age? _____

Do any family members have the following? If yes then please name which family member:

Diabetes ☐ no ☐ yes _____

Hypertension ☐ no ☐ yes _____

Heart Disease ☐ no ☐ yes _____

Alzheimer's ☐ no ☐ yes _____

Blood Clots ☐ no ☐ yes _____

Cancer ☐ no ☐ yes _____
(please specify which type of cancer and list by family member)

Are you having any of these problems **now** or have you experienced them in the **last 6 months**?
(please check all that apply)

☐ Weight gain/loss _____ lbs
☐ Swollen/ Painful Lymph Glands
☐ Change in appetite
☐ Fever/ night sweats
☐ Change in hair/ moles/ skin
☐ Rashes, itching
☐ Headaches/ migraines
☐ Vision change
☐ Ringing in ears
☐ Runny nose
☐ Nose bleeds
☐ Wheezing
☐ Persistent cough
☐ Sputum production
☐ Palpitations
☐ Shortness of Breath
☐ Chest Pain
☐ Abdominal Pain
☐ Vomiting
☐ Vomiting Blood
☐ Constipation
☐ Diarrhea
☐ Urinary frequency
☐ Anxiety, depression
☐ Memory changes
☐ Change in mood
☐ Difficulty sleeping
☐ Dizziness
☐ Incontinence
☐ Penile/ vaginal discharge, sores
☐ Testicular pain, masses
☐ Muscle pain/ stiffness
☐ Redness, swelling in joints
☐ Lower back pain
☐ Change in speech
☐ Numbness, tingling
☐ Easy bleeding, bruising
☐ Heat/ cold intolerance
☐ Change in mole(s) appearance
☐ Shellfish allergies
☐ Sores on tongue
☐ Kidney stones

I personally reviewed this history today with the patient _____ Date _____

PLEASE PRINT

Social Security # _____-____-_____ Birthdate____/____/____Today's date___/____/_____ Sex ☐Male ☐Female

Last Name_____ Suffix_____ First Name_____ Middle Initial_____

Address_____Apt # or P.O. Box_____

City_____ State_____ Zip Code_____ Country_____

Home Phone(___)_____-_____Cell Phone (___)_____-_____ Work Phone(___)_____-_____Ext____

Email Address:_____

Need Interpreter: ☐ YES ☐ NO Language Spoken_____ Preferred Written Language_____

Marital Status ☐Single☐Married☐Divorced☐Widowed Ethnicity:_____ Religion:_____ Race:_____

Employer_____ ☐Full time ☐Part Time ☐ Retired ☐ Disabled

Employer Address_____ City _____ State_____ Zip code_____

Emergency Contact Name_____ Phone# (____)_____-_____Relation_____

Legal Guardian(if applicable)_____

Name of Referring Physician: _____ Phone: _____

Name of Primary Care/ Family Physician: _____ Phone:_____

Name of Medical Oncologist: _____ Phone: _____

Endocrinologist/ Dermatologist/
Gastroenterologist/ GYN/ General Surgeon: _____ Phone:_____

Do you have any known allergies?_____ If so what:_____

Please provide us with a current list of your medications or complete the following:

NAME OF MEDICATION:	DOSE:	HOW OFTEN DO YOU TAKE:

Pharmacy: _____ City/State:_____Phone #:_____

↓ OVER PLEASE ↓

PLEASE PRINT

Social Security # _____-____-_____ Birthdate____/____/____Today's date___/____/_____ Sex ☐Male ☐Female

Last Name_____ Suffix_____ First Name_____ Middle Initial_____

Address_____Apt # or P.O. Box_____

City_____ State_____ Zip Code_____ Country_____

Home Phone(___)_____-_____Cell Phone (___)_____-_____ Work Phone(___)_____-_____Ext____

Email Address:_____

Need Interpreter: ☐ YES ☐ NO Language Spoken_____ Preferred Written Language_____

Marital Status ☐Single☐Married☐Divorced☐Widowed Ethnicity:_____ Religion:_____ Race:_____

Employer_____ ☐Full time ☐Part Time ☐ Retired ☐ Disabled

Employer Address_____ City _____ State_____ Zip code_____

Emergency Contact Name_____ Phone# (____)_____-_____Relation_____

Legal Guardian(if applicable)_____

Name of Referring Physician: _____ Phone: _____

Name of Primary Care/ Family Physician: _____ Phone:_____

Name of Medical Oncologist: _____ Phone: _____

Endocrinologist/ Dermatologist/
Gastroenterologist/ GYN/ General Surgeon: _____ Phone:_____

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NAME OF MEDICATION:	DOSE:	HOW OFTEN DO YOU TAKE:

Pharmacy: _____ City/State:_____Phone #:_____

↓ OVER PLEASE ↓

Mercy
HEALTH SERVICES

BILLING NOTICE TO OUR PATIENTS

The Center for Surgical Oncology is an outpatient department of Mercy Medical Center. Accordingly, you will receive two bills for your appointments in the Center. You will receive a physician services bill from the physician group and an outpatient clinic bill from Mercy. Together, the two bills represent charges incurred during your visit to the Center and we provide this notice to help avoid confusion when you receive two separate bills.

Depending on your insurance coverage, you may be responsible for some or all of both bills. All charges are billed to the patient's insurance company to determine the amount of patient responsibility. If in doubt, please contact your insurance carrier to determine the co-pay, deductible and/or coinsurance amounts.

Thank you.

I have read and understand this billing notice:

Patient Name – Printed	Date of Birth
Patient Signature	Date of Signature

Mercy
HEALTH SERVICES

Authorization for Release of Protected Health Information

Specific Provider or Medical Facility (*List all requested providers and facilities*)

Social Security Number | Date of Birth | Medical Record Number

Last Name | First Name | Middle Initial

Street Address | City | State / Zip Code

I, the undersigned, hereby authorize the above named provider or medical facility to release copies of my medical records. The type of information to be released is as follows:

	Discharge Summary		EKG/Catheterization Reports
	History & Physical		Emergency Room Records
	Laboratory & Radiology Reports		Physician Orders
	Progress Notes		Nurse's Notes
	Operative Reports		Bills
	Any & All Records		Other (specify)

Please release records covering the time period: _____ to _____

Information to be disclosed to: _____

Purpose of disclosure: _____

The Protected Health Information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol and substance abuse, communicable diseases (including (HIV/AIDS) and/or genetic marker information.

I understand and agree to the following:

- MHS does not condition health care treatment I am otherwise entitled to on whether I sign this authorization.
- I understand that the medical records to be accessed may contain medical information pertaining to psychiatric, drug, and/or alcohol, HIV/AIDS diagnosis and treatment.
- This authorization will expire 1 year after the date of my signature below unless a shorter time period is stated here _____. (Must be a time period or date, not an event or condition).
- Information used or accessed under this authorization may be re-disclosed by the recipient and no longer protected by federal law but may be protected under Maryland law.
- I am free to revoke this authorization at any time by submitting a written request to the entity/provider disclosing the records. Any uses or disclosure of my PHI prior to receipt of the revocation can not be reversed and will not be covered by the revocation.

Signature of Patient (or legally appointed representative) | Date | Printed name of legally appointed representative

Authority with documentation provided (Duly appointed Personal Representative, Health Care Power of Attorney, Advanced Directive, Parent of Minor Child, etc.)

Policy Regarding the Completion of Disability Forms and FMLA Paperwork

Please note our office requires two weeks for the completion of disability forms and FMLA paperwork. Also, it may not be possible to complete disability and/or FMLA forms prior to surgery depending on the information required. If we are unable to complete the forms prior to surgery, you will be notified by our office.

We appreciate your understanding and apologize for any inconvenience.